



Objectives

By the end of this session, participants will be able to:

- Understand the POLST Paradigm and how patient wishes are determined and documented in a standard form
- How POLST documentation builds upon and improves existing advance directives
- Describe the relationship between a Power of Attorney for Healthcare and a POLST form, and when each is appropriate for patient completion
- Recognize the importance of healthcare staff being properly educated regarding interpreting POLST forms during emergencies and other relevant circumstances

IDPH DNR Advance Directive... can also be called POLST now

- Illinois is changing the current IDPH DNR Advance Directive to meet the national POLST standards used in other states
- POLST stands for “Physician Orders for Life-Sustaining Treatment”
- POLST reduces medical errors by improving guidance during **life-threatening emergencies**

Evolution of the IDPH DNR Form

2013 – POLST Go-Live

*The IDPH approved form developed by a statewide consortium of providers, ethicists, and other stakeholders becomes widely available, pilot sites begin reporting data, and work on legislation continues.

Benefits of POLST in Illinois

Promoting Patient-Centered Care

- Promotes quality care through **informed** end-of-life conversations and **shared** decision-making
- Concrete **Medical Orders** that **must** be followed by healthcare providers
- Easily recognized **standardized** form for the entire state of Illinois
- Follows patient from **care setting** to care setting

POLST Use in the United States

The POLST Paradigm is now in the majority of states

National POLST Paradigm Programs

- Endorsed Programs
- Developing Programs
- No Program

*As of February 2013

Why Does Illinois Need This Advance Directive?

To Insure Accuracy and Continuity of Patient Wishes Across Care Settings

Ave. of 34 Physician Visits in last 6 months of life **Ave. of 9 Different Physicians in last 6 months of life**

THE DARTMOUTH INSTITUTE FOR HEALTH POLICY & CLINICAL PRACTICE

Who is POLST Designed For?
Focusing on patients as partners in their care.

The POLST form is designed for:

- Patients facing life-threatening complications, regardless of age; and/or
- Patients with advanced frailty and limited life expectancy; and/or
- Patients who may lose the capacity to make their own health care decisions in the next year (such as persons with dementia); and/or
- Persons with strong preferences about current or anticipated end-of-life care.

Screening Question
One Year is a Rule of Thumb...

- A POLST discussion is appropriate if:
 - You would not be surprised if this person died from their illness(es) within the next year
 - The patient suffers from a severe illness and has a preference about the intensity of his/her care

Advance Care Planning Over Time
Maintain and Maximize Health, Choices, and Independence

FIRST STEPS: Complete a PoA. Think about wishes if faced with severe trauma and/or neurological injury.

NEXT STEPS: Consider if, or how, goals of care would change if interventions resulted in bad outcomes or severe complications.

LAST STEPS: End-of-life planning - establish a specific plan of care using POLST to guide emergency medical orders based on goals.

The POLST Form in Illinois

The POLST Document

- 3 Primary Medical Order Sections
 - A. CPR for Full Arrest**
 - Yes, Attempt CPR
 - No, Do Not Attempt CPR (DNR)
 - B. Orders for Pre-Arrest Emergency**
 - Full Treatment
 - Limited Treatment
 - Comfort Only
 - C. Artificial Nutrition and Hydration**
 - None
 - Trial period
 - Acceptable



The POLST Form in Illinois

Physician Orders for Life-Sustaining Treatment

- A Cardio-Pulmonary Resuscitation (CPR)**
- B Medical Interventions**
- C Artificially Administered Nutrition**
- D Documentation of Discussion**
- E Signature of Attending Physician**
- R Reverse Side – Contains More Information and Instructions**



Section "A": Cardio-Pulmonary Resuscitation

Code Status – only when pulse AND breathing have stopped

- There are multiple kinds of emergencies. This section only addresses a **full arrest** event (no breathing or pulse), and answers "Do we do CPR or not?"
- NEW!** Patients can use this form to say YES to CPR, as well as to refuse CPR.

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Section "B": Medical Interventions

Do Not Resuscitate does NOT mean Do Nothing

- Three categories explaining the intensity of treatment when the patient has requested DNR for full arrest, but is still breathing or has a pulse.
 - Comfort – patient prefers symptom management and no transfer if possible
 - Limited – no aggressive treatments such as mechanical ventilation
 - Full – all indicated treatments are acceptable

Stoplight Metaphor for Medical Interventions

Stop – Caution – Go



- Stop (Patient Refusal)
- Caution (Limited Treatment)
- Go (Full Treatment)

Section "B": Medical Interventions

B MEDICAL INTERVENTIONS Patient has pulse and/or is breathing.

- Comfort Measures Only (shower/bath): Relieve pain and suffering through the use of medication by appropriate route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location. Treatment Plan: Maximize comfort through symptom management.
- Limited Additional Interventions: In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation or mechanical ventilation. May consider less invasive airway support (e.g., CPAP/BIPAP). Transfer to hospital if indicated. Generally avoid the intensive care unit. Treatment Plan: Provide basic medical treatments.
- Intubation and Mechanical Ventilation: In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. Treatment Plan: Life support measures, including intubation, in the intensive care unit.

Additional Orders

- Use "Additional Orders" for other treatments that might come into question (such as dialysis, surgery, chemotherapy, blood products, etc.).
- An indication that a patient is willing to **accept** full treatment should not be interpreted as forcing health care providers to offer or **provide** treatment that will not provide a reasonable clinical benefit to the patient (would be "futile").

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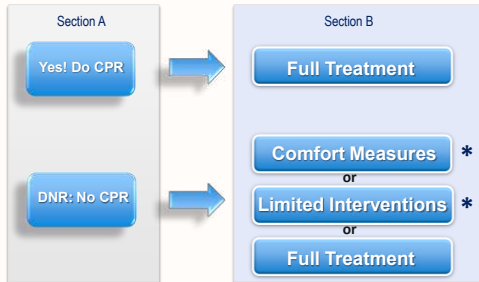
Section "B": Medical Interventions

Yes to CPR in Section A requires full treatment in Section B

- If choosing "Attempt CPR" in Section A, Intubation and Mechanical Ventilation is **required** in Section B.
 - Why? If limited measures fail and the patient progresses to full arrest, the patient will be intubated anyway, thus defeating the purpose of marking Comfort or Limited.

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Section "A" choices influence medical interventions in Section "B"



*Requires documentation of a "qualifying condition" ONLY when requested by a Surrogate.

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For Example...



- 85 year-old gentleman admitted from home through ED with severe **pneumonia**
- The patient is increasingly hypoxic and **may be confused**
- Patient refuses the vent x3.
- There is a **DNR order** on the chart.
- The physician feels DNR does not apply to potentially **reversible** conditions and begins full resuscitation.

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POLST Clarifies Unclear Guidance



- 85 year-old gentleman admitted from home through ED with severe **pneumonia**
- The patient is increasingly hypoxic and **may be confused**
- Patient refuses the vent x3.
- There is a **DNR order** on the chart.
- Comfort only** is marked for medical treatment. Intensive symptom management is started and resuscitation is not initiated.

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For example...

- A 59 year-old woman being treated for **breast cancer** arrives at the ED with sepsis.
- In the ICU**, she is on oxygen and maxed-out on pressors.
- She has a **DNR order** on the chart.
- Staff are concerned they are violating the patient's wishes.



POLST Addresses Ethical Concerns

- A 59 year-old woman being treated for **breast cancer** arrives at the ED with sepsis.
- **In the ICU**, she is on oxygen and maxed-out on pressors.
- She has a **DNR order** on the chart.
- **Limited treatment** is marked for medical treatment. Staff can feel comfortable they are honoring the patient's wishes.



For example...

- 67 year-old gentleman presents to ED with chest pain and SOB.
- He is in pain and confused.
- The cardiologist wants to take him for a **cardiac cath** and possible stent.
- The patient's nurse calls the physician to inform her that the patient has a prior IDPH **DNR order** on the chart.
- There is confusion whether the patient would want to be **sent for the procedure** anyway.



POLST Provides Guidance for Treatment

- 67 year-old gentleman presents to ED with chest pain and SOB.
- He is in pain and confused.
- The cardiologist wants to take him for a **cardiac cath** and possible stent.
- The patient's nurse calls the physician to inform her that the patient has a prior IDPH **DNR order** on the chart.
- **Full treatment** is marked for medical treatment and he is immediately sent for the recommended treatment.



Don't Forget DNR for Procedures...

Best Practice: DNR Is Not Automatically Lifted



- Consent needs to be obtained to change an existing DNR order to full code, even during a procedure
- Discuss appropriateness of DNR in light of procedure and objectives
- If suspended, specify length of time
- Inform procedurists of code status

Creating More Accurate Orders

- Some institutions have created orders to better capture the distinction of these categories, such as **DNR-Comfort**, **DNR-DNI**, or **DNR-Full Treatment**.
- Hospitals are NOT required to complete this form when writing in-hospital DNR orders for the first time.
 - Complete a POLST form if the patient/legal representative wishes to continue DNR code status or limit emergency medical interventions after discharge.



Of 25,000 people in Oregon...

Yes to CPR (28%)

No CPR: DNR (72%)



1/2 of the **DNR** group wanted **hospitalization** and some level of treatment for medical emergencies

1/2 of the **DNR** group wanted only **comfort** measures for medical emergencies

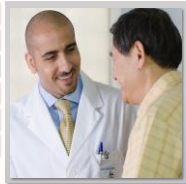
JAMA. 2012;307(1):34-35

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The POLST Form in Illinois

Physician Orders for Life-Sustaining Treatment

- A Cardio-Pulmonary Resuscitation (CPR)
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Section "C": Artificially Administered Nutrition

WANCE DIRECT Check One (optional)	<input type="radio"/> No artificial nutrition by tube.	Offer food by mouth, if feasible and as desired.	ADDITIONAL INSTRUCTIONS Additional Instructions (e.g., length of trial period)
	<input type="radio"/> Defined trial period of artificial nutrition by tube.	_____	
	<input type="radio"/> Long-term artificial nutrition by tube.	_____	

- Nutrition by tube can include temporary NG tubes, TPN, or permanent placement feeding tubes such as PEG or J-tubes.
- A trial period may be appropriate before permanent placement, especially when the benefits of tube feeding are unknown, or when the patient is undergoing other types of treatment where nutritional support may be helpful.

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For example...



- A 91 year-old woman residing in a nursing home has end-stage **dementia** and is increasingly eating smaller and smaller portions
- The physician and Director of Nursing feel the patient **must** have a feeding tube placed or they could be **held liable** for her malnourishment

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POLST Addresses Legal Concerns

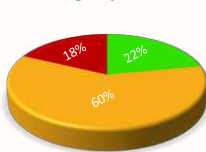


- The patient's only family member, a son, says his mother had always said she did not want a **feeding tube**
- Patients and their legal representatives may use POLST to choose the option of **long-term** artificial feeding, **short-term** artificial feeding, or they may **refuse** this treatment option.

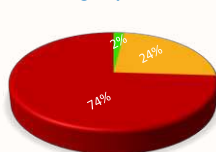
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Of 25,000 people in Oregon...

CPR group



DNR group



- Long-Term feeding tube
- Time-limited Trial
- No feeding tube

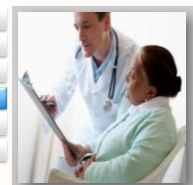
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Section "D": Documentation of Discussion

D DOCUMENTATION OF DISCUSSION (Check all appropriate boxes below)		
<input type="checkbox"/> Patient	<input type="checkbox"/> Agent under health care power of attorney	
<input type="checkbox"/> Parent of minor	<input type="checkbox"/> Health care surrogate decision maker (See Page 2 for priority list)	
Signature of Patient or Legal Representative		
Signature (required)	Name (print)	Date
Signature of Witness to Consent (Witness required for a valid form)		
I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged their signature or mark on this form in my presence.		
Signature (required)	Name (print)	Date

- The form can be signed by:
 - The **patient**
 - The agent with a **PoA** (when the patient does not have decisional capacity)
 - The designated Healthcare **Surrogate**
 - when the patient does not have decisional capacity and has no PoA or applicable Advance Directive
 - a parent of a minor child is a surrogate

Quick Refresher on Decision-Maker Priority

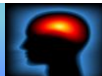
Start at the top and move down the list

- Patient**
 - Do not move on until patient has been evaluated by the attending physician who **documents the patient lacks decisional capacity** and is not expected to regain capacity in time to make this decision
- Power of Attorney for Healthcare**
 - Patient has completed and signed this Advance Directive
- Surrogate** (when you can't speak to patient and no PoA)
 - Guardian of the person
 - Spouse/ Civil partner
 - Adult children
 - Parents
 - Adult siblings
 - Grandparents/children
 - Close Friend



Decisional Capacity

It's not all or nothing.



- Before turning to a PoA or Surrogate, assess and document **Decisional Capacity**.
- The patient may be able to make *some* decisions even if s/he can't make *all* decisions.
 - Patients who are **minors** should be offered the opportunity to participate in decision-making up to their level of understanding
 - Studies consistently show that decisions made by others are **more aggressive** and **not as accurate** as what the patient would choose for him/herself.

Section "D": Documentation of Discussion

- The form should be **witnessed** by a person over the age of 18 who is not a direct care provider, PoA, or Surrogate.
 - Any ancillary staff such as social workers, pastoral care, ethicists, etc. can witness
- When the form is completed by a person other than the patient, it should be **reviewed** with the patient if the patient **regains** decisional capacity to ensure that the patient **agrees** to the provisions.



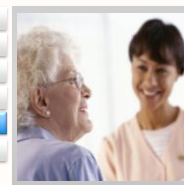
Section "D": Documentation of Discussion

- Adults with POLST are also encouraged to complete a Power of Attorney (PoA).
- Extreme care should be exercised if the PoA or Surrogate wishes to **reverse the direction** of care previously established by the patient
 - For example, the patient requested **Comfort** or **Limited Treatment**, but the PoA or Surrogate wants **Full Treatment**
 - Changes to a form should be based on evidence of the **patient's** wishes

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Section "E": Signature of Attending Physician

- The physician should sign and date the form.

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Requirements for a Valid Form

Use White or Ultra Pink paper



- Patient name
- Resuscitation orders (Section "A")
- 3 Signatures
 - Patient or legal representative
 - Witness
 - Physician
- All other information is optional
- Pink paper is recommended to enhance visibility, but color does not affect validity of form
- Photocopies and faxes ARE acceptable.

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Who Can Assist in Preparing a POLST Form?



- Best practice suggests use of those trained in the POLST Conversation such as (among others):
 - Physicians
 - Social Workers
 - Nurses
 - Chaplains
 - Care Managers
 - Ethicists
 - Physician Assistants and Nurse Practitioners

- Find an example of a POLST conversation at:
<http://www.uctv.tv/search-details.aspx?showID=18360>

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POLST is a Process, Not a Form

POLST form is a documentation tool.



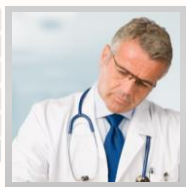
- POLST should not be used as a check-box form, or as a replacement for an informed **conversation** between patients, families and providers to:
 - Identify **goals of treatment**.
 - Make **informed choices**.
- The conversation should be documented in the medical record, along with a copy of the completed POLST form.

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Reverse Side: Guidelines and Instructions

Completion of the form is *always voluntary*.

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Potential System Concerns

1. Signing physician **doesn't have privileges** here
 - Orders still must be translated into specific institutional orders
 - Suggest using "Pt is DNR per IDPH DNR order" and have that order signed by assigned staff attending
2. Our physician has **never seen this patient** before
 - Law indicates DNR must be honored in all care settings
 - **Protected from liability** for following an IDPH DNR form in good faith
3. Developing best practices for **storing, locating**, and transmitting document between care settings
 - Institutions should standardize where the document is located so that it is easily available during an emergency, but also protects the patient's privacy

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What Should I Do with an Older IDPH DNR Form?



- Continue to **follow** older IDPH DNR Advance Directives.
- **Update** the older form to the new form when it is feasible.
- **Review** the form with the patient or legal representative when a change in the patient's medical condition, goals, or wishes occurs

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This presentation for the POLST Illinois Taskforce has been made possible by in-kind and other resources provided by:



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Training Events

- If you are attending a formal POLST training event, PLEASE help us with our quality improvement efforts and grant obligations by:
 - Signing in for attendance
 - Complete your survey and turn it in
 - Look for and complete a follow-up email in about 6 weeks

THANK YOU!

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